tients suffer impairment in their abilities to think and to maintain social relationships. Indeed, their social networks are smaller than those of normal people. It therefore makes sense to develop interventions that help these networks better support their patient members.

DAVID SPIEGEL, MD
Stanford, California

REFERENCES

Anderson CM, Hogarty GE, Reiss DJ: Family treatment of adult schizophrenic patients: A psycho-educational approach. Schizophr Bull 1980; 6:491-505

Brown GW, Birley JLT, Wing JK: Influence of family life on course of schizophrenic disorders: A replication. Br J Psychiatry 1972 Sep; 121:241-258

Falloon IRH, Boyd JL, McGill CW, et al: Family management in the prevention of exacerbations of schizophrenia—A controlled study. N Engl J Med 1982; 306:1437-1440

Hogarty GE, Goldberg SC: Drug and sociotherapy in the aftercare of schizophrenic patients. Arch Gen Psychiatry 1973 Jan; 28:54-64

Spiegel D, Wissler T: Family environment as a predictor of psychiatric rehospitalization. Am J Psychiatry 1986 Jan; 143:56-60

Childhood Depression—A Recent Phenomenon?

ADOLESCENT DEPRESSION and some of its manifestations in violence, anger, suicide and substance abuse have been described and a good deal of research conducted into the etiology, diagnosis and treatment. Only within the past five years or so has any attention been paid to depression in children, with the documentation of both severe depression with suicidal ideation and suicide attempts in young children of primary school age.

In several adolescent suicide studies, an effort to retrospectively study the behaviors and school records of actual suicides has revealed some common diagnostic criteria. Review of the cumulative records of ten suicidal adolescents—that is, actual suicides and severe previous attempts—shows that by the third, fourth and fifth grades there were signs of academic failure, the children were described as loners without friends and almost every teacher described them as looking sad. Parent conferences showed chronic alcoholism of one or both parents or divorce (or both). Death of a parent or sibling was also frequently noted. Histories of child physical and sexual abuse were found in four of the ten cumulative records.

A current review of the indicators of childhood abuse has been important in helping educators to identify children at risk for abuse and subsequent depression or antisocial, angry behavior toward children and adults.

Recently depression has been documented in preschool children in the general population. The Children's Affective Disorder Scale was administered and a parent rating scale given; teachers' observations of sad, isolated or overly hostile children were closely correlated with the results of the tests.

Treatment of children who are depressed has reportedly been successful. Similarly aged children with similar problems have benefited from group therapy with a trained group leader. For very young children, activity or play groups provide peer interaction and tangible signs of adult concern and caring. Family therapy or, at least, work with a parent or parents to demonstrate how caring can be shown by attention to a child's productions of drawings or play is effective in reducing depression. Playing games is often mutually enjoyable to parents and children after the parents have been helped to be playful. Dealing with abusive parents by reporting them to child protective services may or may not remove the abusive parent but should halt the abuse once a child and family are being monitored.

The use of antidepressive medications, especially the tricyclic antidepressants, has proved effective in doses of 25 to 50 mg per day, depending on the size of a child.

We are obviously not talking about childhood depression due to hospital admission for acute physical disease or depression due to dealing with chronic illness like diabetes or life-threatening diseases. Physicians who see children and families can often identify the child who looks sad or despondent or who is nonresponsive to anyone's efforts to engage the child in conversation. At our Children's Psychiatric Hospital where children from age 3 years to 15-year-old adolescents are treated as inpatients, many young depressed patients have been referred by physicians. These are children who have experienced multiple stresses. Some have been abused and have also lost a parent through divorce or death. Many of these children not only appear sad but have great difficulty in trusting adults and have sleeping problems, generally nightmares. Some of these children have retreated into psychotic behavior, hearing threatening voices and staring off into space as if they have visual hallucinations. These children have done well with a combination of antidepressant medications and a caring staff, effective group and individual therapy and an effective special education program that promotes a better self-image through increased competence.

IRVING N. BERLIN, MD
Albuquerque

REFERENCES

Berlin IN: Psychopathology and its antecedents among American Indian adolescents. Adv Clin Child Psychol 1986; 9:125-152

Carlson GA, Cantwell DP: Suicidal behavior and depression in children and adolescents. J Am Acad Child Psychiatry 1982 Jul; 21:361-368

Kashani JH, Holcomb WR, Orvaschel H: Depression and depressive symptoms in preschool children from the general population. Am J Psychiatry 1986 Sep; 143:1138-1143

Kashani JH, Husain A, Shekim WO, et al: Current perspectives on childhood depression: An overview. Am J Psychiatry 1981; 138:143-153

Pfeffer CR, Plutchik R, Mizruchi MS, et al: Suicidal behavior in child psychiatric inpatients and outpatients and in nonpatients. Am J Psychiatry 1986 Jun; 143:733-738

Antidepressant Treatment for Bulimia

CERTAIN ANTIDEPRESSANT MEDICATIONS, particularly imipramine hydrochloride, desipramine hydrochloride and the monoamine oxidase inhibitor phenelzine sulfate, are useful in treating bulimia, the binge-purge syndrome. Double-blind studies have shown the superiority of an active medication over placebo, whether or not the bulimic patient is clinically depressed. Although as many as 75% of bulimic patients may be depressed, anxiety and personality disorders often coexist as well. The mechanisms of action of the medications are unclear, but may be through effects on anxiety or depression or more directly.

While medications may be effective, individual and group therapies using cognitive-behavioral methods that attend to eating patterns, nutrition and psychological issues have about the same success rate as does the use of medications alone. Nevertheless, several of the medication studies were conducted primarily with patients for whom previous trials of psychotherapy had failed.

The prudent approach to treating bulimia is to provide both psychological and nutritional counseling with a carefully worked out meal plan. If a patient does not improve within